PRINTED: 08/05/2009 FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVS6551ICF 06/01/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2860 E. CHEYENNE AVENUE MISSION PINES NURSING & REHABILITATION CTR NORTH LAS VEGAS, NV 89030 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) W 000 **INITIAL COMMENTS** W 000 This Statement of Deficiencies was generated as a result of complaint investigation conducted in your facility on 6/1/09, in accordance with Nevada Administrative Code, Chapter 449, Intermediate Care Facilities. Complaint #NV00021945 was substantiated with deficiencies cited (See Tag 104).

The POC must relate to the care of all patients and prevent such occurrences in the future. The intended completion dates and mechanism(s) established to assure ongoing compliance must be included.

A Plan of Correction (POC) must be submitted.

Monitoring visits may be imposed to ensure on-going compliance with regulatory requirements.

The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.

W 104 449.692 SANITARY REQUIREMENTS SS=H

4. Cleaning of the premises and equipment must be performed as needed to protect the health of the residents and staff. The facility must have the necessary cleaning and maintenance equipment with storage facilities and appropriate procedures for regular cleaning and routine maintenance as evidenced by a clean establishment maintained and in good repair.

W 104

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Appeared to have repairs completed to the smoke detector on the ceiling, however, no new paint applied and the ceiling was discolored due to water damage and the recent repairs.

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the ceiling following repair of the sprinkler pipe

The cabinet which enclosed the room sink was

and head.

chipped

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no new paint applied.

-Resident Room #617

There was visual signs of paint discoloration on the ceiling and paint was flaking off the walls.

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continued to experience issues of cleanliness and general appearance. The facility has been cited

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